REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Secretary of State for Health, Jeremy Hunt MP, House of Commons, London SW1A 0AA
1	**CORONER** I am Simon Raymond Nelson, HM Assistant Coroner for the Coroner Area of Manchester West.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 25th of January 2017 I commenced an investigation into the death of Peter O'Donnell, aged 77 years. The investigation concluded at the end of the inquest on the 13th March 2018. The conclusion of the Inquest was:- Against a background of extensive pre-existing natural disease Peter O'Donnell died from a recognised complication of necessary surgical intervention. The medical cause of death was certified as:- Ia Multiple organ failure Ib Sepsis Ic Hospital acquired pneumonia following hip replacement II Ischaemic heart disease
4	**CIRCUMSTANCES OF THE DEATH** The deceased was admitted to the private Beaumont Hospital on the 14th January 2017 for an elective right total hip replacement which proceeded uneventfully. On the morning of the 16th January he presented with symptoms of a chest infection. Thereafter by reason of ineffective communication between professionals; irregular observations and inadequate documentation opportunities to escalate his care were missed. Antibiotic therapy was significantly delayed. The deceased's subsequent deterioration in particular from shortly before midnight on the 17th January 2017 went unrecognised until the decision to transfer him to the Royal Bolton Hospital was made at approximately 11:00 hours on the 18th January 2017. He suffered a cardiac arrest at 20:25 hours that day following which he did not regain consciousness with the fact of death being confirmed at 16:20 hours on the 21st January 2017.

5	**CORONER'S CONCERNS**

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During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

During the Inquest evidence was heard that:-

1. Whilst an in-patient the care afforded to the deceased was consultant led. The consultant in question was an independent consultant orthopaedic surgeon who confirmed the absence of any formal agreement regarding the criteria in which he would be subsequently called into the hospital to undertake a review of his patient. The consultant maintained that it would be useful to have a document that detailed the circumstances of any future intervention. In the course of the inquest I was handed a copy of a report entitled "No Safety without Liability" written by the Centre for Health and the Public Interest (available at www.chpi.org.uk). Within that report is a recommendation that private hospital companies should directly employ surgeons, anaesthetists and physicians who work at their hospitals and should take on responsibility for monitoring their activities and appraising their performance. In this instance neither communication nor escalation procedures were documented.
2. A single Junior Doctor (Resident Medical Officer) was the sole Clinician providing post-operative care for patients. He was on duty 24/7 and asserted that a daily review of each patient would be adequate (although this would be a minimum and would depend on the condition of the individual patient). Both the monitoring and appraisal of each RMO remained with an outside Employment Agency rather than the private hospital in which they were based. Responsibility for training was similarly unclear.
3. Neither protocols nor procedures existed for the transfer of unwell patients to local acute hospitals. Following the death of Mr O'Donnell the Beaumont and local acute Hospital Trust liaised to formulate a proforma document which would detail the rationale for the transfer as well as including all relevant clinical information which would benefit the receiving Hospital. It is by no means certain that such procedures and documentation exist beyond this jurisdiction of Manchester West.
4. Private hospitals should be required to adhere to the same reporting requirements as NHS Hospitals in order to improve the chance of harm to patients being detected.
5. Following Mr O'Donnell's death BMI Healthcare on behalf of the Beaumont Hospital instigated a root cause analysis investigation in the course of which it became clear that two registered General Nurses who were involved in the care afforded to Mr O'Donnell made a number of additions to both the observations chart and nursing notes after Mr O'Donnell had been transferred to the acute Hospital in direct contravention of Clause 10.3 within the Code detailing professional standards of practice and behaviour for Nurses and Midwives issued in 2015.

	Whilst the BMA instigated its own independent disciplinary investigation I believe that the Nurse's actions should have been reported forthwith to the Nursing and Midwifery Council as I believe would be the case in the public sector. Reporting should be mandatory in the private hospital sector.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th May 2017. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- 1. [redacted] (Sister) 2. Fieldings Porter Solicitors 3. BMI Healthcare 4. [redacted] NES Healthcare 5. Royal Bolton Hospital 6. Hempsons Solicitors – [redacted] 7. Centre for Health and Public Interest I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

	Dated	**Signed**
	20th March 2018	**Simon R Nelson, Assistant Coroner**